

SERFF Tracking Number: PRLF-127005281 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 47832  
Company Tracking Number:  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Group Life Portability Termination Revision  
Project Name/Number: /

## Filing at a Glance

Company: Principal Life Insurance Company

Product Name: Group Life Portability

Termination Revision

TOI: L04G Group Life - Term

Sub-TOI: L04G.500 Other

Filing Type: Form

SERFF Tr Num: PRLF-127005281 State: Arkansas

SERFF Status: Closed-Approved-  
Closed

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Bonnie Blue, Mark Curtis, Disposition Date: 01/31/2011

Jan Majerus, Ann McCoy

Date Submitted: 01/28/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Trust

Filing Status Changed: 01/31/2011

State Status Changed: 01/31/2011

Created By: Jan Majerus

Corresponding Filing Tracking Number:

Filing Description:

RE Group Life Insurance Forms

- Booklet-Certificate Form: GH 110 (PORT)-2

Principal Life Insurance Company NAIC No. 61271-332

FEIN # 42-0127290

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jan Majerus

Enclosed for your consideration and approval is a revised insert page to be used with Booklet-Certificate Form GH 106 (PORT), et al issued for Arkansas residents under a master trust policy citused in Delaware. This certificate is issued

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when an Arkansas policyholder's plan of benefits offers a portability option and a covered employee's coverage terminates and the employee elects to continue coverage. These booklet-certificate forms were originally filed and approved in your state on March 26, 2004.

We have added text to the termination section to clarify that if the member becomes insured again for the life insurance coverage under the prior policy for which the group life portability was a replacement, then the portability insurance will terminate. Our change has been italicized and is shown in red.

Also enclosed is a copy of the portability application (GP53450-01) which has been previously filed and approved by your Department on August 5, 2010.

We are attaching all required certification forms.

Thank you for your consideration of this submission.

If you have any questions on any of the attached materials, please feel free to contact me by fax, e-mail or at the number shown below.

## Company and Contact

### Filing Contact Information

Jan Majerus, State/Federal Compliance Analyst Majerus.Jan@principal.com  
711 High Street 800-986-3343 [Phone] 83337 [Ext]  
K-005-E81 515-246-2491 [FAX]  
Des Moines, IA 50392-0002

### Filing Company Information

Principal Life Insurance Company	CoCode: 61271	State of Domicile: Iowa
711 High Street	Group Code: 332	Company Type: Life & Health
Des Moines, IA 50392-0002	Group Name:	State ID Number:
(800) 986-3343 ext. [Phone]	FEIN Number: 42-0127290	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$0.00
Retaliatory?	No
Fee Explanation:	one form X \$50.00 per form

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$50.00	01/28/2011	44173807

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/31/2011	01/31/2011

<i>SERFF Tracking Number:</i>	<i>PRLF-127005281</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47832</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.500 Other</i>
<i>Product Name:</i>	<i>Group Life Portability Termination Revision</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## **Disposition**

Disposition Date: 01/31/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	How to Be Insured - Member Life Insurance [Member Accidental Death and Dismemberment Insurance		Yes

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## Form Schedule

### Lead Form Number: GH 110 (PORT)-2

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GH 110 (PORT)-2	Certificate	How to Be Insured - Member Life Insurance [Member Page, Accidental Death and Endorsement or Rider Insurance	Revised	Replaced Form #: GH 110 (PORT)-1 Previous Filing #: 46352		GH 110 _PORT_-2.pdf

## **HOW TO BE INSURED – MEMBERS**

### **MEMBER LIFE INSURANCE**

### **[MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE]**

#### **Eligibility**

To be eligible for insurance you must be a Member.

You will be eligible on [the first of the Insurance Month coinciding with or next following] the date you become a Member as defined in GH 114.

[In no circumstance will you be eligible for Member Life Insurance under the Group Policy if you are eligible under any other Group [Voluntary] Term Life Insurance policy underwritten by Us.]

[Note: You are not eligible for coverage under the Group Policy if insurance under the Prior Policy ends because the Prior Policy terminates and is replaced by another group [voluntary] policy.]

#### **Individual Incontestability**

All statements made by any insured person [(you or one of your Dependents)] will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form, which contains the statement, is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premium and benefits to reflect the correct age.

#### **Assignments**

[No assignments of Member Life Insurance will be allowed under the Group Policy.]



[Only assignments of Member Life Insurance will be allowed under the Group Policy and only if:

- [- they are not collateral assignments or assignments for consideration; and]
- they are in Written form and recorded at Our home office in Des Moines, Iowa.

We will assume no responsibility for the validity of effect of any assignment.]

### **Proof of Good Health**

In some instances, Proof of Good Health will be required to place your insurance in force. We will determine the type and form of required proof. You will need to file Proof of Good Health:

- If you have failed to provide required Proof of Good Health or you have been refused insurance under the Group Policy at any prior time.
- [- To make effective any Scheduled Benefit amount increase for you that is, in excess of:
  - [- [[two] times Annual Compensation not to exceed] [\$60,000] if you are under age [65]; and]
  - [- [[two] times Annual Compensation not to exceed] [\$30,000] if you are age 65 or over but under age 70; and]
  - [- [[two] times Annual Compensation not to exceed] [\$10,000] if you are age 70 or over.]]
- [- To make effective any request for a Scheduled Benefit amount increase.]
- [- To make effective any request to change your [or your Dependent spouse's [or Domestic Partner's]] smoking status classification.]

### **Effective Date for Insurance (Proof of Good Health Not Required)**

You must request insurance in a form provided by Us.

Your insurance will normally be in force on [the first of the Insurance Month coinciding with or next following] the date you are eligible, if you make your request within 60 days after the date you are eligible.

### **Effective Date for Insurance (Proof of Good Health Required)**

If Proof of Good Health is required, your insurance will normally be in force on the later of:

- The date insurance would have been effective had Proof of Good Health not been required; or
- [The first of the Insurance Month coinciding with or next following] the date Proof of Good Health is approved by Us.

#### **[Effective Date for Benefit Changes Due to Changes by Policy Amendment]**

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to your coverage under the Group Policy for which Proof of Good Health is not required (see above) will be effective on the date of change. [Exception: Any decrease in Scheduled Benefit amounts due to a change by amendment to your coverage under the Group Policy will be effective on the date of change.]

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to your coverage under the Group Policy for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- [the first of the Insurance Month coinciding with or next following] the date Proof of Good Health is approved by Us.]

#### **[Effective Date for Benefit Changes Due to Changes Requested by the Member]**

A change in your Scheduled Benefit amount due to your request for which Proof of Good Health is not required (see above), will be effective on [the first of the Insurance Month coinciding with or next following] [the [June 1] that next follows] the date of the request. [Exception: Any decrease in Scheduled Benefit amounts will be effective on [the date noted above] [the date of the change].]

A change in your Scheduled Benefit amount due to your request for which Proof of Good Health is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- [the first of the Insurance Month coinciding with or next following] the date Proof of Good Health is approved by Us.]

### **[Effective Date for Benefit Changes Due to a Change in the Member's Family Status]**

You may request an increase in Scheduled Benefits, a decrease in Scheduled Benefits, or the addition of Scheduled Benefits for which you were not previously insured if a change in your family status as described below has occurred, provided a request for such increase, decrease, or addition is made in Writing within [31] days after the date of the change in family status:

- marriage [or declaration of a Domestic Partner relationship] or divorce [or termination of a Domestic Partner relationship];
- death of your spouse [or Domestic Partner] or child;
- birth or adoption of a child;
- termination of employment by your spouse [or Domestic Partner] or a change in your spouse's [or Domestic Partner's] employment that causes loss of group coverage;
- your employment or your spouse's [or Domestic Partner's] employment changes from part-time to full-time or from full-time to part-time;
- you or your spouse [or Domestic Partner] takes an unpaid leave of absence.

A change in the Scheduled Benefits because of a request by you when a change in family status has occurred for which Proof of Good Health is not required (see above) will normally be effective on [the first of the Insurance Month coinciding with or next following] the date of the request. [Exception: Any decrease in Scheduled Benefit amounts due to your request, will be effective on [the date noted above] [the date of the change].]

A change in the Scheduled Benefits because of a request by you when a change in family status has occurred for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or
- [the first of the Insurance Month coinciding with or next following] the date Proof of Good Health is approved by Us.]

### **Termination**

Your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates, either in its entirety or for you; or
- [- the date your Member Accidental Death and Dismemberment Insurance ceases; or]

- [the end of the Insurance Month for which] [the date] the last premium is paid for your insurance; or
- [the end of any Insurance Month] [any date desired], if requested by you before that date[; or
- [the [May 1] that next follows] [the end of the Insurance Month in which] [the date] you reach [75] years of age][; or
- [the [May 1] that next follows] the date your coverage has been in force [two] [three] [five] years][; *or*
- *the date you become insured again under the Prior Policy as a Member*].

### **Termination for Fraud**

We may at any time terminate a person's eligibility under the Group Policy:

- in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, when an individual has submitted a claim, which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

### **[Insurance While Outside of the United States**

If you [or a Dependent] are temporarily outside the United States, you [or your Dependent] may choose to continue insurance, subject to premium payment for a period of [six months] or less for one of the following reasons:

- [- personal travel; or]
- [- a business assignment; or]
- [- full-time student status, provided you [or your Dependent] are either:
  - enrolled and attending an accredited school in a foreign country; or
  - participating in an academic program in a foreign country, for which the institution of higher learning at which you [or your Dependent] are enrolled in the U.S. grants academic credit.]

[The [six-month] period will not be reduced for any time covered under a Prior Policy.]

If you [or your Dependent] are outside the United States for any other reason than those listed above or longer than a period of [six months], coverage for the person concerned will automatically terminate.

[Note: This provision is not applicable to United States citizens who live in the U.S. but work at an employer location in Canada or Mexico.]

Your insurance may be reinstated under the reinstatement provision described on GH 118 and subject to the provisions of the Group Policy.]

### **Continuation**

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with Us before your insurance terminates.

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Readability Cert.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application <b>Comments:</b> <b>Attachment:</b> GP53450-01.pdf		

**STATE OF ARKANSAS  
INSURANCE DEPARTMENT**

**CERTIFICATION OF READABILITY**

I, Kimberly Douglas, an Officer of Principal Life Insurance Company hereby certify that the attached form(s) has (have) achieved a Flesch Reading Ease Score of:

Form No.	Form Name	Flesch Score
GH 110 (PORT)-2	Group Life Portability Life Booklet-Certificate Form	55.3

and complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

PRINCIPAL LIFE INSURANCE COMPANY



Kimberly Douglas, Director  
Group Life and Health Compliance

January 28, 2011 \_\_\_\_\_  
Date

12/1999





Mailing Address:  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Group Term  
Life Insurance  
Portability Application

Account number \_\_\_\_\_

### Employee & Dependent (if applicable) Information

I hereby apply for portability of my group term life insurance coverage issued by Principal Life Insurance Company in accordance with the provisions of the group policy.

Employee name (last, first, middle initial) \_\_\_\_\_ Sex ☐ male ☐ female

Street address \_\_\_\_\_ Phone number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Name	Social security number	Date of birth	Relationship	Amount of coverage
			Self	\$
				\$
				\$
				\$

**NOTE:** Standalone dependent coverage is not available.

### Beneficiary Designation

Full name \_\_\_\_\_ Relationship to insured \_\_\_\_\_

### Employee Signature (Read and sign below.)

- Upon receipt of this application, a premium statement will be issued by Principal Life indicating the premium and the premium due date. The premium due date may be on a monthly, quarterly or annual basis as elected by the insured person and agreed upon by Principal Life.
- I hereby certify that the above information is true and complete to the best of my knowledge and belief. I understand my coverage can be ported as long as I:
  - do not meet the definition of actively at work which includes a reduction in work hours from full time to part time;
  - am less than 75 years of age;
  - am not currently on premium waiver due to disability;
  - am not receiving accelerated benefits;
  - am not exercising individual purchase rights.
- I understand ported coverage amounts can be increased with proof of good health. Coverage can also be decreased or cancelled at any time. Coverage changes due to family status are also allowed and proof of good health will apply according to the portability policy provisions. Coverage ends as specified in the portability policy or at the time premiums are no longer being paid. I do have conversion rights.
- **I have read and understood the fraud notice requirements on Page 2.**

Employee signature \_\_\_\_\_ Date signed \_\_\_\_\_



**Employer to Complete this Section**

Employer name \_\_\_\_\_

Was the above named employee on disability or receiving accelerated benefits when coverage ended?      yes      no

Amount of coverage upon termination \_\_\_\_\_

Employee \$ \_\_\_\_\_ Dependent \$ \_\_\_\_\_ Dependent children \$ \_\_\_\_\_

Date last worked \_\_\_\_\_ Date coverage ended \_\_\_\_\_ Annual salary \$ \_\_\_\_\_

**Notice Requirements**

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

**COLORADO FRAUD**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA FRAUD**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA FRAUD**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY FRAUD**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**LOUISIANA FRAUD**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW MEXICO FRAUD**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**PENNSYLVANIA FRAUD**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE FRAUD**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**VIRGINIA FRAUD**

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.